WHO IS TO CERTIFY COMPETENCE IN A SPECIALTY? *

WILLIAM P. LONGMIRE, JR., M.D.

Department of Surgery
School of Medicine
University of California at Los Angeles
Los Angeles, Calif.

CERTIFICATION in a specialty signifies the attainment of a specified level of knowledge, skill, and experience in a defined area of medical practice. Its primary objective should be to provide the public with a high quality of specialty care. Broadly stated, specialty certification could be the responsibility of one of three agencies:

1) *The profession*, through the mechanism of a single professional organization or a consortium of such bodies.

2) *The medical schools*, as a part of the advanced degree program.

3) *A governmental agency*, either as an extension of the present state licensure procedure or by a new federal program.

The present system in the United States of specialty board certification by the profession has worked surprisingly well as a purely voluntary, self-sustaining apparatus without official status. This system has the advantage of placing the process of certification in the hands of those best qualified to evaluate professional competence. National standards for certification have been developed and the process is accepted by an overwhelming majority of practicing physicians as satisfactory evidence of expertise in a specialty. The system has been criticized for fragmenting the direction and supervision of graduate medical training, for being unresponsive to the needs of the public, for being the tool of a self-perpetuating group designed to protect the specialists rather than the public, and for being rigid and unrealistic in its requirements, techniques, and criteria. Many of these criticisms, if justified, could be rectified by relatively small alterations in the present structure. The chief difficulty with the present system, however, is that it is purely

*Presented in a panel, Who Is to Certify Competence in a Specialty? as part of a *Symposium on the Changing Scene in Graduate Medical Education* held by the Committee on Medical Education of the New York Academy of Medicine October 26, 1973.

voluntary and must depend primarily on public opinion for its effectiveness in modifying the care of patients.

There is, of course, little reason to certify specialists unless such certification is meaningful and has impact on the quality of medical care. What mechanisms are available to achieve these goals, and how do they relate to the question of who is to certify competence in a specialty?

First is the *restriction of hospital privileges.* When some type of uniform, nationally established, and nationally recognized level of competence, such as board certification, is the principal criterion for the granting of hospital privileges to specialists, then this mechanism is partially effective. Political problems within the hospital, legal responsibility for unfair restraint, and the ability of the untrained "specialist" to move to an adjacent hospital with less rigid requirements reduce the effectiveness of this mechanism.

When individual hospitals attempt to establish their own standards of specialty requirements and levels of competence without reference to national standards, a bewildering maze of standards develops which overwhelms the comprehension of the public and, at times, even of the profession. Such individual local rules have been challenged by recent court decisions in malpractice cases, where it was ruled that the appropriateness of the care should not be judged on the basis of usual and customary local practices but, rather, on nationally recognized standards. If the Joint Commission on Accreditation of Hospitals (JCAH) were to establish, as a requirement for the approval of a hospital, the certification of all its staff physicians who render specialty care, this would serve as a most effective method of strengthening the impact of certification on national health care. Approval by the JCAH is essential to an institution today that wishes to be eligible for payment from a variety of governmentally financed programs of medical care.

Another possible mechanism is the *restriction of fees,* wholly or in part, paid by governmental and private third-party insurers for specialty services not performed by certified specialists. Such a system is currently utilized by several foreign countries and could be employed in conjunction with any system of certification. Most easily, it could be written into laws that establish certification as a function of state or federal government.

The third available mechanism is the *passage of state or federal laws*

to define the requirements of specialty certification. The actual process of certification could be delegated to other agencies, such as the present specialty boards, or the governmental agencies might prefer to create their own techniques of certification along the lines of the present state board examinations. This method would be the most difficult to attain but would be the strongest and most effective means of insuring that specialty certification influences the quality of health care. The idea of such firm governmental control, however, is not attractive to the public in general and is actually appalling to the majority of members of the medical profession.

On the basis of the experience in this and other countries, the present system of certification by the profession seems to have the most appeal. However, governmental support—by payment for specialty services only to certified physicians, by a differential pay scale with higher fees paid to qualified specialists, or even by laws regulating specialty practice—is needed if certification is to have its maximum impact on health care.